FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: South Dakota
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

_____
(Signature of Agency Head)

Date: 03-31-2000

Reporting Period: 07-01-1998 through 09-30-1999

Contact Person/Title: Janet Lehmkuhl, Assistant Program Administrator
Pat Suedkamp, Nurse Consultant

Address: 700 Governor's Drive, Pierre, South Dakota 57501-2291

Phone 605-773-3495 Fax 605-773-5246

Developed by the National Academy for State Health Policy

Email Medicaid@DSS.state.sd.us

SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

The Census Bureau Current Population Survey (CPS) annually estimates the number of children below 200% of the Federal Poverty Level who are uninsured in each state. The annual estimates are based on 3 years of survey data and updated each year. We have selected these CPS figures as our baseline for this report.

Census Survey	Number of Uninsured Children
CPS 1993, 1994, 1995	17,000
CPS 1994, 1995, 1996	10,000
CPS 1995, 1996, 1997	12,000
CPS 1996, 1997, 1998	13,000
South Dakota 1999 Estimate*	10,909
South Dakota 2000 Estimate*	6,943

* Census estimates reduced by enrollment

These data are the latest available from CPS, all of the survey periods are prior to the July 1, 1998 implementation of M-SCHIP in South Dakota, however they are the best available basis to use as our baseline. Examining the numbers shows a large reduction from the 1995 survey to the 1996 survey. This reduction can possibly be explained by a Medicaid

expansion that took place in July of 1995. This expansion provided Medicaid coverage to children under 100% of the Federal Poverty Level (FPL) and born after July 1, 1983. The increases from 1996 to 1997 can be explained through a combination of change in the definition of insurance to exclude the IHS as an 'insurance' and sample variability.

1.1.1 What are the data source(s) and methodology used to make this estimate?

Baseline estimates were prepared using the Census Bureau Current Population Survey from 1995, 1996, 1997 and 1998. Estimates for 1999 and 2000 baseline figures are calculated by reducing the 1998 CPS estimate by the number of uninsured children enrolled in South Dakota Medicaid and South Dakota M-SCHIP on the last day of each reporting year. The following table reports the number of enrolled Medicaid and M-SCHIP children for the ending date of each quarter from M-SCHIP implementation to the end of Federal Fiscal Year 1999. Throughout this report when the number of Medicaid eligible children is referred to it includes all categories of Medicaid eligible children except SSI Medicaid eligible children.

Quarter Ending	Medicaid Children	M-SCHIP Children
06/30/1998 *	32,859	-0-
09/30/1998	34,290	903
12/31/1998	35,320	1,407
03/31/1999	36,435	1,710
06/30/1999	36,866	2,039
09/30/1999	37,158	2,488

* Last Quarter Prior to M-SCHIP Implementation
Source: South Dakota MMIS 1998, 1999

Extracted data from the MMIS over this time period revealed that 83% of the children enrolled in Medicaid were uninsured when considering all types of insurance including full coverage, and limited coverage plans including hospital only, dental and cancer. All M-SCHIP children were by definition, uninsured.

Children enrolled in Medicaid prior to July 1, 1998 were children age 0-5, under 133% of the Federal Poverty Level (FPL) and children 6-18 under 100% Federal Poverty Level and all other Medicaid categories. Children enrolled in Medicaid after July 1, 1998 include children age 6-18 under 133% of FPL and all previously eligible categories. Effective April 1, 1999 children age 0-18 under 140% of FPL were also included. Children enrolled in M-SCHIP prior to April 1, 1999 are targeted uninsured children, not otherwise eligible for Medicaid ages 6-18, and under 133% FPL. After April 1, 1999 the eligibility level for M-SCHIP children was increased to 140% of FPL. The following table shows the

increases in the number of uninsured Medicaid and M-SCHIP individuals for each of the FFY 1998 and FFY 1999.

Medicaid - M-SCHIP Enrollment of Uninsured Children				
Baseline Year	Reporting Period	Uninsured Medicaid	M-SCHIP	Total
1999	06/30/1998-09/30/1998	1,188	903	2,091
2000	10/01/1998-09/30/1999	2,381	1,585	3,966

Reducing the baseline estimate of 13,000 uninsured children from 1998 by the enrollment of uninsured children in Medicaid yields estimates of 10,909 after the first FFY of M-SCHIP operation and 6,943 after the second FFY of M-SCHIP.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The Current Population Survey from the US Census Bureau is the best baseline data source available for South Dakota for the reporting periods.

Selection of actual enrollment data from Medicaid and M-SCHIP is the most reliable information available, as we know with certainty the children are covered, how the number of children covered has changed over the reporting periods, and we know the insurance status of each of the children. Using the entire Medicaid except SSI children population rather than low-income categories strengthens the projections as movement between Medicaid categories is addressed, as well as capturing the overall increase in the number of children enrolled in Medicaid. Using actual enrollment figures also improves over the use of unduplicated "ev

If anything, we suspect the baseline numbers are slightly high because of the decision to use actual enrollment figures for each quarter. The alternative of counting "ever enrolled" children even if they had coverage for only 1 month of the year does not add credibility to the numbers, but would result in a lower baseline estimate of the remaining numbers of uninsured children.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How

many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

The following table shows the percentage reduction in the number of uninsured children following each federal fiscal year of M-SCHIP operation.

Period	1998 Estimate of Uninsured Children	Medicaid Increase	M-SCHIP Increase	Total	Remaining Uninsured Children	Percentage Reduction in Uninsured Children
07/01/1998-09-30-1998	13,000	1,188	903	2,091	1999 - 10,909	16%
10-01-1998-09-30-1999		2,381	1,585	3,966	2000 - 6,942	36%
07-01-1998-09-30-1999		3,569	2,488	6,057	6,942	47%

The following Table shows that Medicaid and M-SCHIP have both contributed substantially to reducing the number of uninsured children in South Dakota. Recognizing that the baseline figures represent all uninsured children below 200% of the federal poverty level and that Medicaid and M-SCHIP eligibility expansions were directed at incomes below 133% of FPL prior to April 1, 1999 and at incomes to 140% of FPL after April 1, 1999 the impact on very low incomes has been proportionally greater.

Year Ending	Baseline	Baseline 133%	Enrollment	Reduction %
09/30/1998	13,000	8,662	2,091	24%
09/30/1999	10,909	5,985 - 6,284 **	3,966	63% - 66%

* Assumed uniform distribution of uninsured children less than 200% by income

* In April eligibility increased to 140% FPL, so baseline figure is represented as a range of the percent of uninsured children between 133%-140%.

1.2.1 What are the data source(s) and methodology used to make this estimate?

The data source and methodology used is the same as in 1.1.1.

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

The assessment of the reliability of the estimate is the same as in 1.1.2.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, numerators, denominators, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
Achieve a measurable reduction in the number of uninsured children in South Dakota.	1. Implement Medicaid expansion to cover uninsured children age 6 through 18 to 133% FPL through a CHIP State Plan on 07/01/1998, enrolling 7,352 children by 06-30-1999 and increasing enrollment by 5% each year after the initial year.	1. Narrative: An M-SCHIP plan was developed and submitted to HCFA on 06/05/1998 with approval being received on 08/25/1998. The plan was implemented on July 1, 1998. Data Sources: US Census Bureau Current Population Survey, 1995, 1996, 1997, 1998. SD MMIS, MR 63 June 1998 - September 1999. Methodology: Reduce 1998 CPS baseline by actual enrollments in M-SCHIP. Numerator: FFY 1998 M-SCHIP enrollment 903 FFY 1999 M-SCHIP enrollment 1,585 Denominator: FFY 1998 Baseline Uninsured children 13,000 FFY 1999 Baseline Uninsured children 10,909 Progress Summary: Reduction in uninsured children FFY 1998 7% Reduction in uninsured children FFY 1999 15% Narrative: Immediate reductions in the number of uninsured children occurred in 1998 as a result of the M-SCHIP program providing creditable health coverage. The goal of enrolling 7,352 children in M-SCHIP after one year of operation was not met as

Table 1.3		
		2,039 were enrolled. This figure represents a reduction of 16% in the number of uninsured children. When Medicaid enrollment is factored in the number of children gaining creditable coverage is 6,057 or 82% of the stated goal. South Dakota feels the original goal of 7,352 was incorrectly estimated in the State of a result of limited information available regarding uninsured children in South Dakota when the program was designed.
	2.Extend Medicaid to uninsured children age zero through eighteen at Medicaid eligibility levels in effect prior to 07-01-98, enrolling 900 additional children by 06-30-99 and increasing enrollment by 1% each year after the initial year.	2. Data Sources: US Census Bureau Current Population Survey, 1995, 1996, 1997, 1998. SD MMIS, MR 63 June 1998 - September 1999. Methodology: Reduce 1998 CPS baseline by actual enrollments in Medicaid. Numerator: FFY 1998 Medicaid enrollment increase 1,188 FFY 1999 Medicaid enrollment increase 2,381 Denominator: FFY 1998 Baseline Uninsured children 13,000 FFY 1999 Baseline Uninsured children 10,909 Progress Summary: Reduction in uninsured children FFY 1998 9% Reduction in uninsured children FFY 1999 22% Narrative: The goal of enrolling 900 additional children in Medicaid was exceeded by nearly 400%. The goal was established at an unrealistic number as a result of the limited information on uninsured children when the program was designed.

Table 1.3		
	3. Utilize a systematic approach to identify uninsured children with low incomes using Department data resources, partnerships with other public programs, and local involvement of interested parties including schools, providers, and others by July 1, 1998 and continuing each year.	3. Department enrollment data, Department Field Program Specialist (FPS) reports, Eligibility assistance offices, HCFA 64.21E report. Methodology: Review data to show increase in enrollment, Review of FPS reports for outreach contacts, Eligibility assistance application process. Narrative: Internal Department methods that were used to identify uninsured children included direct mailings to specific households. Approximately 1,400 families that had children under 6 on Medicaid and also had a child 6-18 in the household who was not on Medicaid received M-SCHIP information. Applications were made available to these families. The households of approximately 14,000 children ages 6-18 who were on the Food Stamp Program were sent information on M-SCHIP. The Office of Child Care Services has mailed approximately 2,000 information sheets regarding M-SCHIP to child care assistance recipients, potential child care assistance recipients, and Daycare providers. This is an ongoing effort by the Office of Child Care Services. A newsletter with M-SCHIP information was sent to approximately 5,000 Medicaid providers. A Web page was implemented with M-SCHIP information and a Field Program Specialist contacts list. Contacts with Child Protection and Low Income Energy Assistance Programs were initiated to implement distribution of M-SCHIP information. Department of Social Services District Field Program Specialists conducted informational meetings on M-SCHIP in local communities that included: Physician clinics and offices, Hospitals, Optometry offices, Mental Health Centers, School nurses, Headstarts, County Welfare offices, Dental offices, Job Service, Ministerial Associations, Pharmacies, Counseling services, WIC, Children's Special Health

Table 1.3		
		Services, Schools, Day Care Centers, Community Health offices, County offices, Extension offices, Kiwanis, Jaycees, Battered Women shelters, Homeless shelters, libraries, Community Health Centers, public housing, Adult Education Centers, College Student Health Centers, Nursing Student programs, Senior Citizen Centers, professional organizations, Interagency Coordinating Councils, Food Pantries, Boys and Girls Clubs, YMCA, Chamber of Commerce, Job Training Centers, workplaces, Laundromats, grocery stores, Community Health Fairs, community events, fast food restaurants, Salvation Army,Resource Centers for Women, Poor Relief agencies, Urban Indian Health Centers, United Way, Congressional offices, Legal Services, Post Office, Community banquets, banks, convenience stores, Children's Advocacy groups, Migrant Councils, Wellness Centers, Tribal agencies, BIA agencies, employers, media including newspaper and public radio. Other public programs include: Department of Health, Children's Special Health Services Program, Caring Program, Tribal agencies and BIA agencies, Headstarts, School Lunch Program, Department of Education. Tribal involvement has included applications and information packets that were mailed out to their local offices. IHS has also been a willing participant in the distribution of Title XXI enrollment materials. Federal Qualified Health Care Centers have had their staff trained to assist families in the application process for eligible children. Initial meetings were held with the "Healthy Child Care America" initiative-planning group to network M-SCHIP information and enrollment materials. The Caring Program mailed cover letters to their 284 enrollees informing them of the implementation of M-SCHIP. Outreach efforts with the above providers, agencies, and community groups is an ongoing process as M-SCHIP continues to identify and enroll children to meet the goal of insuring children.

Table 1.3		
	4. Simplify the Medicaid application process for low-income children using a shortened application and accepting mail-in applications by July 1, 1998.	4. Data Sources: Department of Social Services/Eligibility assistance. Methodology: Eligibility assistance offices. Progress Summary: Goal met by 100%. Narrative: The application form was simplified and shortened from 9 pages to 3 pages. A worksheet to help figure eligibility by income was added to the application along with a county listing of the local offices where application may be made or information requested. Applications can be mailed into the local DSS offices. This mail in feature, as well as the other revisions noted above were implemented July 1, 1998. Attachment 1: Application Form
	5. Increase the number of Department of Social Services personnel to support the enrollment of uninsured children by 12 full time equivalent workers by June 30, 1999.	5. Data Sources: Internal department data, SD DSS Office of Field Management Methodology: Analysis of caseload due to M-SCHIP enrollees. Progress Summary: SD has employed 14 more Full Time Equivalent (FTE) personnel to support the enrollment and application of M-SCHIP children. Twelve FTE's are located in the local field offices through out the state, and two are in the state office. We have exceeded the goal.

Table 1.3

OBJECTIVES RELATED TO CHIP ENROLLMENT

Achieve a measurable reduction in the number of uninsured children in South Dakota.	Implement Medicaid expansion to cover uninsured children age 6 through 18 to 133% FPL through a CHIP State Plan on 07/01/1998, enrolling 7,352 children by 06-30-1999 and increasing enrollment by 5% each year after the initial year.	Narrative: An M-SCHIP plan was developed and submitted to HCFA on 06/05/1998 with approval being received on 08/25/1998. The plan was implemented on July 1, 1998. Data Sources: US Census Bureau Current Population Survey, 1995, 1996, 1997, 1998. SD MMIS, MR 63 June 1998 - September 1999. Methodology: Reduce 1998 CPS baseline by actual enrollments in M-SCHIP. Numerator: FFY 1998 M-SCHIP enrollment 903 FFY 1999 M-SCHIP enrollment 1,585 Denominator: FFY 1998 Baseline Uninsured children 13,000 FFY 1999 Baseline Uninsured children 10,909 Progress Summary: Reduction in uninsured children FFY 1998 7% Reduction in uninsured children FFY 1999 15% Narrative: Immediate reductions in the number of uninsured children occurred in 1998 as a result of the M-SCHIP program providing creditable health coverage. The goal of enrolling 7,352 children in M-SCHIP after one year of operation was not met as 2,039 were enrolled. This figure represents a reduction of 16% in the number of uninsured children. When Medicaid enrollment is factored in the number of children gaining creditable coverage is 6,057 or 82% of the stated goal. South Dakota feels

Table 1.3		
		the original goal of 7,352 was incorrectly estimated in the State of a result of limited information available regarding uninsured children in South Dakota when the program was designed.
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Achieve a measurable reduction in the number of uninsured children in South Dakota.	Extend Medicaid to uninsured children age zero through eighteen at Medicaid eligibility levels in effect prior to 07-01-98, enrolling 900 additional children by 06-30-99 and increasing enrollment by 1% each year after the initial year.	Data Sources: US Census Bureau Current Population Survey, 1995, 1996, 1997, 1998. SD MMIS, MR 63 June 1998 - September 1999. Methodology: Reduce 1998 CPS baseline by actual enrollments in Medicaid. Numerator: FFY 1998 Medicaid enrollment increase 1,188 FFY 1999 Medicaid enrollment increase 2,381 Denominator: FFY 1998 Baseline Uninsured children 13,000 FFY 1999 Baseline Uninsured children 10,909 Progress Summary: Reduction in uninsured children FFY 1998 9% Reduction in uninsured children FFY 1999 22% Narrative: The goal of enrolling 900 additional children in Medicaid was exceeded by nearly 400%. The goal was established at an unrealistic number as a result of the limited information on uninsured children when the program was designed.

Table 1.3

OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Improve access to quality primary and preventive health care services under Medicaid for SCHIP eligibles, new Medicaid eligibles, and previously non-enrolled children.	Enroll all newly approved M-SCHIP children in the South Dakota Medicaid primary care case management program within 1 month of their enrollment, beginning 07-01-98.	Data Sources: Local eligibility workers and Managed Care System. Methodology: Average Managed Care Participation for M-SCHIP enrollees. Averages based on enrollment numbers from 08-01-98 through 09-30-99. July 1998 enrollment numbers were excluded due to the PCP selection time period enrollees are permitted. Attachment 2: Managed Care enrollment data Progress Summary: 98.6% of the M-SCHIP children have a Primary Care Provider (PCP) by the start of the second month of enrollment, either chosen by the applicant or assigned by Managed Care (MC) staff if not chosen. A few children are exempt from Managed Care for specific reasons such as enrollment in boarding school, custody of state agency, or if they have a complex life threatening disease and are in specialized medical care programs. Due to these exceptions we feel we the goal should be revised to 97%. Narrative: Recipients are informed of Primary Care Case Management (PCCM) opportunities when their applications are approved. Recipients receive a PCCM information sheet that explains the MC program and how to access services within the guidelines of the MC program, along with a list of the PCP's who are participating in the program. A recipient is given a minimum of 10 days to select a PCP, if a PCP is not chosen within 30 days, a PCP is assigned by the MC program staff.

Table 1.3		
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Improve access to quality primary and preventative health care services under Medicaid for SCHIP eligibles, new Medicaid eligibles, and previously non-enrolled children.	1.Ensure each new SCHIP enrollee and New Medicaid eligibles receive EPSDT information at the time their eligibility is approved.	1. Data Sources: Local Eligibility Assistance/DSS workers. Methodology: Packet of EPSDT information given to Medicaid and M-SCHIP enrollees. Progress Summary: All new enrollees are sent this information as part of the enrollment process. Narrative: The changes in the enrollment process make it no longer necessary to have a face to face interview to apply for Medicaid and M-SCHIP. As a result necessary information with a cover letter is mailed to the recipient households. Included in this packet of information is a brochure explaining and promoting the "Healthy Kids Klub". The Healthy Kids Klub program promotes preventative healthcare services through the EPSDT program. The following information is also included in the packet: Rights and Responsibilities - Medical Programs information sheet, Managed Care Selection Form, Primary Care Provider List(specific to applicants location), The South Dakota Medicaid Managed Care Program information sheet, Emergency Room Services information, South Dakota Medicaid Covered Services and Payment Information sheet, Healthy Kids Klub brochure, and a facsimile of the Medicaid card. Keeping recipient households informed of immunizations and well childcare visits that are age appropriately due is done by reminder letters. An average of 6,688 reminder notifications are sent out to Medicaid and M-SCHIP households per month. An immunization project is currently in progress in an effort to increase immunization rates of recipients, and notices are being sent to providers giving them lists of recipients who

Table 1.3		
		are delinquent on their immunizations. Attachment 3: Healthy Kids Klub brochure and EPSDT Notification Letter
	2. Develop a quality measurement mechanism that includes measures of immunization, well childcare, adolescent well care, satisfaction and other measures of health care quality.	2. Data Sources: South Dakota Immunization Information System, MMIS, Department M-SCHIP survey. Methodology: Focused review of each identified area resulting in a report. Numerator: 9 reports Denominator: 9 reports Progress Summary: Measures completed for each of the identified performance measures in the state plan. Narrative: In future years the M-SCHIP studies may be broadened. Attachments 4 through 12 : #4 Immunization Study, #5 Well Child Care Study, #6 Optometric Study, #7 Mental Health Study/Eating Disorders, #8 Asthma Study(ER utilization and Appropriate Medication), #9 Substance Abuse Study, #10 Dental Study, #11 Satisfaction of Health Care/Department Survey 1998 and #12 Satisfaction of Health Care/Department Survey 1999.

Table 1.3		
OTHER OBJECTIVES		
Develop better measurement capabilities of health insurance coverage, health care service availability and quality to children in South Dakota.	1. Develop survey capabilities with the Department of Health to measure the insurance coverage of children in South Dakota by 07-01-98.	1. Data Sources: Department of Health/ 1999 Behavioral Risk Factor Surveillance System Survey (BRFSS). Progress Summary: BRFSS is underway and collecting information with quarterly reports being generated. Narrative: The BRFSS is an ongoing telephone health survey funded by the Federal Centers for Disease Control and Prevention that is conducted in all fifty states, the District of Columbia and three territories. Specific insurance coverage questions were developed and put into operation in the existing BRFSS survey starting January 1998 and significantly expanded in January 1999. The data is provisional at this time and not yet ready to be used for baseline analysis. Attachment # 13: BRFSS surveys 1998 and 1999.
	2. Modify the MMIS to make M-SCHIP tracking and reporting capabilities available to measure enrollment, service, utilization, and overall program effectiveness.	2. Data Sources: MMIS, HCFA forms 64.EC and 64.21E. Methodology: Modification of MMIS to record and report M-SCHIP data. Progress Summary: System has been modified to include the M-SCHIP children as a distinct category of eligibles, enabling all MMIS functions. Narrative: Numbers of children enrolled can be tracked for reporting purposes to

Table 1.3		
	3. Develop capability to measure access to coverage for Indian children in South Dakota by working jointly with the Indian Health Service, Tribal governments and Urban Indian Health clinics by 07-01-00.	HCFA. Claims information is available on M-SCHIP recipients. This will continue to be a source of information for M-SCHIP. 3. Data Sources: Managed Care Provider Enrollment Methodology: Review of Primary Care Provider enrollment locations and caseload distributions for M-SCHIP recipients. Enrollment report data. Attachment # 14: Indian Health Service Primary Care Provider (PCP) List Progress Summary: Maintaining a data base on the number and location of providers including IHS and UIH facilities that serve as PCP's to our managed care recipients. Ongoing efforts to develop an information exchange system with IHS facilities to utilize their immunization data for our statewide immunization project. All 20 IHS facilities in south Dakota and 1 IHS facility in North Dakota along with two UIH facilities in the state are participating as PCP's. The American Indian M-SCHIP recipients are given the opportunity to select the PCP of their choice. They can receive services at IHS and UIH facilities even if they have not selected those providers as their PCP. Narrative: There are 35.5% or 244 American Indian M-SCHIP recipients using IHS and UIH facilities as of 03-01-00. Our department is working with IHS to develop a database on Immunizations and a grant proposal to interface data exchange on immunizations. This will enable analysis of access to services and sharing of immunization data for this population.

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

_X_ Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: __South Dakota Children's Health Insurance Program

Date enrollment began (i.e., when children first became eligible to receive services): _____07-01-98_____

___ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs. NA

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs. NA

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

The South Dakota Medicaid program greatly influenced the design of the M-SCHIP program in South Dakota. The most significant factor contributed by the Medicaid program was the availability of covered benefits that were appropriate for the health care of children. This benefit package included the availability of broad dental, optometry services, and many other services under EPSDT, as well as some services provided by schools. Another very significant factor considered in the design of our M-SCHIP program was the ability to equalize eligibility for all children in families at 133% of FPL (Federal Poverty Level). The availability of a PCCM managed care construct in Medicaid was also recognized as a desirable benefit for M-SCHIP children.

The availability of an established service delivery network and existing administrative structure also offered numerous advantages that were considered in the design of the M-SCHIP program. Most notably the short time frame required to implement a statewide program and the limited additional administrative expenditures that were required influenced the selection of a Medicaid expansion as M-SCHIP program.

The strong direct care presence of the Indian Health Service in South Dakota was also an influencing factor in the design of the South Dakota M-SCHIP program. With many potential beneficiaries of M-SCHIP services in South Dakota being eligible for services from the IHS, a program that collaborated effectively with the IHS was essential. South Dakota Medicaid did have the participation history with IHS providers and American Indian beneficiaries so that the IHS could continue to play a key role in outreach and providing services to American Indian children under M-SCHIP.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

_X_ No pre-existing programs were "State-only"

___ One or more pre-existing programs were "State only" ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

2.2.3. Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

During the short time period that has elapsed in M-SCHIP implementation the health care environment in South Dakota has remained relatively stable. The key gains in promoting access to affordable health care for children has been the M-SCHIP and associated Medicaid expansion.

The health care delivery system in South Dakota continues to change as several large provider based networks of hospitals and physician practices continue to expand throughout the state. The delivery system is also continuing to see an increase in the number of specialized hospital service providers in certain larger markets of the state. Access to health care in rural areas continues to be a challenge in South Dakota so that affordable health care is available statewide.

Managed care still has a limited impact in South Dakota. The most recent

managed care inroads have been in the development of Medicare Plus plans aimed primarily at seniors rather than the general population or children.

The health care system in South Dakota continues to be very concerned over the financial pressures associated with Medicare BBA reductions and the discounts sought by private sector payors.

Recent years have not seen the government driven health care reforms that were present nationally and in South Dakota during the middle 1990's like HIPAA, PRWORA, and BBA. Most of the reforms under these acts were initiated prior to M-SCHIP and implementation continues through the time period covered by this report. Statewide healthcare reforms have been limited in scope.

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

_X_ Changes to the Medicaid program

___ Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
___ Provision of continuous coverage (specify number of months ___)
_X_ Elimination of assets tests
_X_ Elimination of face-to-face eligibility interviews
_X_ Easing of documentation requirements

Along with the above changes the application process has been made easier for applicants. The application has been simplified by making it shorter and offering mail in applications. Applications are also available at various community and provider locations. Another positive feature is the same Caseworker that determines M-SCHIP eligibility also determines eligibility for other programs for low-income families such as Food Stamps, TANF and Medicaid. The Caseworkers were able to identify families who had children that might meet the M-SCHIP eligibility guidelines. See 1.2 for enrollment growth in M-SCHIP and Medicaid since the implementation of M-SCHIP.

_X_ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)
Based on Urban Institute estimates (Attachment #15), South Dakota was one of only 10 states that had increases in Medicaid enrollment for FY 1995-1997 when Welfare Reform was taking place. The South Dakota computer system was

revised to separate TANF and Medicaid eligibility to assure Medicaid eligibles were not "lost" during the transition.

___ Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

- ___ Health insurance premium rate increases
- ___ Legal or regulatory changes related to insurance
- ___ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
- ___ Changes in employee cost-sharing for insurance
- ___ Availability of subsidies for adult coverage
- ___ Other (specify) _____

___ Changes in the delivery system

- ___ Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)
- ___ Changes in hospital marketplace (e.g., closure, conversion, merger)
- ___ Other (specify) _____

___ Development of new health care programs or services for targeted low-income children (specify) _____

___ Changes in the demographic or socioeconomic context

- ___ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)_____
- ___ Changes in economic circumstances, such as unemployment rate (specify) _____
- ___ Other (specify)_____
- ___ Other (specify) _____

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1

	Medicaid CHIP Expansion Program Implemented 07-01-1998	**Medicaid CHIP Expansion Program Implemented 07-01-1998: Amended 04-01-1999**	**State-designed CHIP Program**	**Other CHIP Program***
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	Statewide	Statewide	NA	NA
Age	6 through 18	6 through 18 0 through 5	NA	NA
Income (define countable income) [1]	100>133% FPL	6 through 18 between 100>140% FPL 0 through 5 between 133>140% FPL	NA	NA
Resources (including any standards relating to spend downs and disposition of resources)	Not Counted	Not Counted	NA	NA
Residency requirements	Resident of South Dakota	Resident of South Dakota	NA	NA
Disability status	Not a factor.	Not a factor.	NA	NA
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	May not be covered at time of application.	May not be covered at time of application.	NA	NA

[1] See Addendum to Table 3.1.1 at end of this document.

Other standards (identify and describe) [2]	Must meet US Citizenship requirements of the Medicaid program.	Must meet US Citizenship requirements of the Medicaid program.	NA	NA

2 US citizen or meet certain requirement if an alien.

**Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".*

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Monthly	Families are required to report changes in income or circumstances if change from initial application, otherwise yearly review.	NA	NA
Every six months	NA	NA	NA
Every twelve months	Full redetermination.	NA	NA
Other (specify)	NA	NA	NA

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

___ Yes ° Which program(s)?

For how long?

_X_ No

3.1.4 Does the CHIP program provide retroactive eligibility?

_X_ Yes ° Which program(s)? M-SCHIP

How many months look-back? 3 months back if eligible, the same as Medicaid.

___ No

3.1.5 Does the CHIP program have presumptive eligibility?

___ Yes ° Which program(s)?

Which populations?

Who determines?

_X__ No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

_X__ Yes

Is the joint application used to determine eligibility for other State programs? If yes, specify.

_X__ No However, if an individual is applying for the TANF and/or Food Stamp programs, that more comprehensive application may be used to also apply for M-SCHIP and Medicaid.

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

The Eligibility determination process has been greatly strengthened because of the simplified application process and the shortened application form. This makes it much easier for the applicant to enroll in the program. Another positive aspect is the same Department of Social Service (DSS) Caseworker that determines M-SCHIP eligibility also determines eligibility for other programs for low-income families such as Food Stamps, TANF and Medicaid. This feature insures referral to other programs that are available for the families. The information used for a Food Stamp and/or TANF application can be used to determine M-SCHIP and/or Medicaid eligibility thus eliminating duplication in the application processes. The caseworkers are available to assist in the completion of the application and are encouraged to re-contact the families that make an M-SCHIP application and do not complete the application process. Documentation verification requirements are minimal and include earned and unearned income, and child support payments if they are not through the State Child Support office.
Attachment # 1: Application form

The Department M-SCHIP surveys sent to families in December 1998 and December 1999 netted positive response rates of 95% and 98% respectfully in regards to the question about the ease of the application process. We contribute this high rate of positive responses to the changes that were made in the application process and application making it easier for families to enroll in M-SCHIP and Medicaid.

South Dakota M-SCHIP enrollment begins effective the date of approval. M-SCHIP coverage begins the 1st day of the month of application, or three months prior if eligible. A study of M-SCHIP applications (01/01/1999 - 02/15/2000) showed that the average number of days pending an application was 16.39.
The following table shows the length of time to process an application and supports our conclusion that it is an effective process.

641 cases processed from 01-01-1999 - 02-15-2000	
Processing (pending) days	Percentage of cases processed
0 -10	48%
11-20	18%
21-30	15%
31-45	19%

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

The redetermination process mirrors the initial application process and has many of the same advantages. M-SCHIP redetermination is annual, and utilizes the same forms as the initial eligibility determination process. An added benefit in redetermination is that the caseworker gets the material to the family to complete in the month prior to the month the redetermination is due. Caseworkers are encouraged to contact the family if there is no response back from the family during the redetermination process.

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Table 3.2.1 CHIP Program Type Medicaid CHIP Expansion			
Benefit	Is Service Covered? (**T** = yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	T		
Emergency hospital services	T		
Outpatient hospital services	T		
Physician services	T		
Clinic services	T		
Prescription drugs	T		
Over-the-counter medications	No		
Outpatient laboratory and radiology services	T		
Prenatal care	T		
Family planning services	T		
Inpatient mental health services	T		Prior authorization required.
Outpatient mental health services	T		Unlimited from physicians and community health centers; limited to 40 hours of individual therapy from other professionals in a 12-month period.
Inpatient substance abuse treatment services	T		Under EPSDT South Dakota covers inpatient treatment up to 45 days per year. Days may be extended if determined medically necessary by Division of Drug and Alcohol, Department of Human Services.
Residential substance abuse treatment services	T		Inpatient services are limited to 45 days in a 12-month period.

Outpatient substance abuse treatment services	T		Under EPSDT South Dakota covers outpatient treatment up to 60 hours in a 12-month period.
Durable medical equipment	T		A limited number of devices require prior authorization.
Disposable medical supplies	T		
Preventive dental services	T		
Restorative dental services	T		When medically necessary.
Hearing screening	T		
Hearing aids	T		
Vision screening	T		
Corrective lenses (including eyeglasses)	T		
Developmental assessment	T		
Immunizations	T		
Well-baby visits	T		
Well-child visits	T		
Physical therapy	T		
Speech therapy	T		
Occupational therapy	T		
Physical rehabilitation services	T		
Podiatric services	T		
Chiropractic services	T		Only manual manipulation of the spine. Limited to 30 visits per 12-month period.
Medical transportation	T		

Home health services	T		
Nursing facility	T		
ICF/MR	T		
Hospice care	No		
Private duty nursing	T		Prior authorization.
Personal care services	T		
Habilitative services	T		
Case management/Care coordination	T		PCCM-PRIME Waiver 1915 B (1) Attachment # 16: South Dakota Managed Care Waiver
Non-emergency transportation	T		
Interpreter services	No		
Other (Specify)			
Other (Specify)			
Other (Specify)			

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

Children enrolled in the M-SCHIP program in South Dakota may receive all of the covered services available to Medicaid recipients including the EPSDT services. These services include all the mandatory Medicaid services and number of optional services as highlighted in 3-2-1.

Physician Services – Mandatory	Podiatry – Optional
Rural Health Clinics – Mandatory	Psychologists – Optional
Federally Qualified Health Centers - Mandatory	Clinic Services – Optional
Inpatient – Mandatory	Physical Therapy – Optional
Outpatient – Mandatory	Speech Therapy – Optional
Other Medical – Mandatory	Prescription Drugs – Optional
Ambulance – Mandatory	Nursing Services – Optional
Medical Equipment – Mandatory	Optical (Eyeglasses) – Optional
Crossovers – Mandatory	Prosthetic Devices – Optional
EPSDT Screening – Mandatory	Clinic Services for At-risk Pregnant Women – Optional
EPSDT Dental – Mandatory	Chiropractic Services – Optional
EPSDT Optometric – Mandatory	Adult Dental – Optional (except adult surgical)
EPSDT Treatment – Mandatory	Optometrists – Optional
Part A Premiums – Mandatory	Renal Disease - Optional
Part B Premiums – Mandatory	
BBA Expanded SMI – Mandatory	
Indian Health Services – Mandatory	

Included in these services are a full range of preventive and treatment services under EPSDT. Included with preventive services are physician screenings, mental health screenings, dental, optometric, speech and hearing screenings, and immunizations. Included as EPSDT treatment services are a full array of dental services including necessary orthodontic, vision services, speech therapy, and hearing devices. Substance abuse and mental health treatment services include inpatient psychiatric hospital, inpatient psychiatric facility, residential treatment services, and inpatient chemical dependency services. Outpatient mental health and substance abuse treatment services

are covered, including physician, psychologist, certain social workers, counselors, community mental health centers and outpatient chemical dependency providers. EPSDT also provides coverage of certain transplant procedures and other medically necessary services beyond the normal scope of covered Medicaid benefits.

Most services provided under M-SCHIP are under Primary Care Case Management (PCCM) program operated under 1915(b) waiver authority. Within 30 days of enrollment in the M-SCHIP program, families must choose a primary provider from a list of South Dakota physicians that includes family and general practice, obstetricians, gynecologists, pediatricians, and internists. Indian Health Service facilities, Federally Qualified Health Centers, and Rural Health Clinics are also available as primary care providers. Services of a medical nature are included as a managed care service and non medical services such as dental, optometry, chiropractic, emergency, and family planning services are outside the scope of managed care and enrollees have free choices of providers. All services are reimbursed on a fee for services basis.
Attachment # 17: Managed Care Referral Card and Information Sheet

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3

Type of delivery system	Medicaid CHIP Expansion Program Yes	State-designed CHIP Program NA	Other CHIP Program* NA
A. Comprehensive risk managed care organizations (MCOs)	NA	NA	NA
Statewide?	___ Yes ___ No NA	___ Yes ___ No NA	___ Yes ___ No NA
Mandatory enrollment?	___ Yes ___ No NA	___ Yes ___ No NA	___ Yes ___ No NA
Number of MCOs	NA	NA	NA
B. Primary care case management (PCCM) program	Yes	NA	NA
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	Yes - Delta Dental of South Dakota	NA	NA
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	All services are Fee For Service	NA	NA
E. Other (specify)	NA	NA	NA
F. Other (specify)	NA	NA	NA
G. Other (specify)	NA	NA	NA

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, and coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

_X__ No, skip to section 3.4

___ Yes, check all that apply in Table 3.3.1

Table 3.3.1

Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*_____ _____ _
Premiums			
Enrollment fee			
Deductibles			
Coinsurance/copayments**			
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".
**See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

___ Employer
___ Family
___ Absent parent

___ Private donations/sponsorship
___ Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

___ Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
___ Other (specify)_____

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (**T**=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1

Approach	Medicaid CHIP Expansion Yes		State-Designed CHIP Program NA		Other CHIP Program* NA	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Billboards	No	NA				
Brochures/flyers	T	4				
Direct mail by State/enrollment broker/administrative contractor	T(By State only not contractor)	3				
Education sessions	T	5				
Home visits by State/enrollment broker/administrative contractor	No	NA				
Hotline 1-800- Number	T	3				
Incentives for education/outreach staff	No	NA				
Incentives for enrollees	No	NA				
Incentives for insurance agents	No	NA				
Non-traditional hours for application intake	No	NA				
Prime-time TV advertisements	No	NA				
Public access cable TV	T	2				
Public transportation ads	No	NA				

Developed by the National Academy for State Health Policy

Radio/newspaper/TV advertisement and PSA's	T	2				
Signs/posters	T	3				
State/broker initiated phone calls	No	NA				
Other (specify) Collaboration with other State programs and departments	T	4				

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (**T**=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2

Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Battered women shelters	T	3				
Community sponsored events	T	3				
Beneficiary's home	T	2				
Day care centers	T	2				
Faith communities	T	1				
Fast food restaurants	T	1				
Grocery stores	T	2				
Homeless shelters	T	3				
Job training centers	T	3				
Laundromats	T	1				
Libraries	T	1				
Local/community health centers	T	4				
Point of service/provider locations	T	4				
Public meetings/health fairs	T	3				

Public housing	T	3				
Refugee resettlement programs	T	3				
Schools/adult education sites	T	4				
Senior centers	T	1				
Social service agency	T	5				
Workplace	T	2				
Other (specify) Professional newsletters	T	2				
Other (specify) Professional organizations	T	2				
Other (specify) Interagency Coordinating Councils	T	3				
Other (specify) Food Pantries	T	4				
Other (specify) Local/County governmental agencies/representatives	T	4				
Other (specify) Boys/Girls clubs/YMCA	T	3				
Other (specify) Headstarts	T	4				
Other (specify) Mental Health Clinics/Counseling Services	T	3				
Other (specify) Colleges/Student Health	T	2				
Other (specify) Chamber of Commerce	T	2				
Other (specify) Salvation Army	T	4				
Other (specify) Community Groups/Jaycees	T	3				
Other (specify) ICAP	T	3				

Other (specify) Resource Centers for Women	T	3				
Other (specify) Poor Relief agencies/or Other organizations	T	4				
Other (specify) Urban Indian Health Centers	T	4				
Other (specify) United Way	T	3				
Other (specify) Congressional offices	T	2				
Other (specify) Legal Services	T	2				
Other (specify) Post Office	T	2				
Other (specify) Community Banquets	T	4				
Other (specify) Banks	T	2				
Other (specify) Laundromats/Gas stations/ Convenience stores	T	2				
Other (specify) Wellness Centers	T	3				
Other (specify) Food Pantries	T	4				
Other (specify) Refugee Community leaders/ Migrant Councils	T	3				
Other (specify) Children's Advocacy Groups	T	4				
Other (specify) WIC/Community Health Offices	T	4				
Other (specify) Tribal agencies/BIA agencies and contacts	T	4				

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

Growth in <u>TOTAL</u> Children covered by Title XXI and Title XIX

Since June 1998(06-19-98 through 09-30-99) the number of children (excluding SSI children) in South Dakota on Medicaid including those enrolled in M-SCHIP increased by 7,492 which is a 21% increase in **total enrolled** children. The **total** Medicaid enrollment of children for FFY 1998 Third Quarter was 34,890. The combined enrollment numbers as of 09-30-99 for both M-SCHIP and Medicaid is 42,382 children, consisting of 2,489 enrolled in M-SCHIP and 39,894 children enrolled in Title XIX Medicaid. Title XIX, Medicaid program has seen an increase of 5,004 children in all program eligibility categories for a 14% increase in enrollment during the period 07-01-1998 through 09-30-1999.

M-SCHIP Enrollment

The following table illustrates the growth in monthly enrollment for all M-SCHIP children from July 1998 to September 1999, and enrollment for the total Medicaid population of children including M-SCHIP enrollees by age categories. The June 1998 data does not reflect M-SCHIP data, as M-SCHIP began July 1, 1998. However under the column 'Total Medicaid Children including M-SCHIP by Age Categories' June 1998 data is included to show the increase in enrollment after the initiation of M-SCHIP. The data for the following table was obtained from MMIS.

M-SCHIP Children Total Enrollment by Age Categories					**Total Medicaid Children including M-SCHIP by Age Categories (no M-SCHIP for 6-98)**			
Month	**0 - 5**	**6 - 12**	**13 - 18**	**Total**	**0 - 5**	**6 - 12**	**13 - 18**	**Total**
06-98	NA	NA	NA	**NA**	15,807	14,192	4,891	**34,890**
07-98	NA	249	103	**352**	15,955	14,781	6,018	**36,754**
08-98	NA	500	187	**687**	16,039	15,267	6,189	**37,495**
09-98	NA	649	255	**904**	16,167	15,609	6,359	**38,135**
10-98	NA	780	315	**1,095**	16,248	15,908	6,472	**38,628**
11-98	NA	882	350	**1,232**	16,328	16,066	6,530	**38,924**
12-98	NA	992	413	**1,405**	16,481	16,356	6,722	**39,559**
01-99	NA	1,088	469	**1,557**	16,513	16,535	6,839	**39,887**
02-99	NA	1,176	485	**1,661**	16,626	16,812	7,012	**40,450**
03-99	NA	1,223	487	**1,710**	16,760	17,034	7,176	**40,970**

04-99	0	1,255	513	**1,768**	16,828	17,143	7,271	**41,242**
05-99	0	1,341	544	**1,885**	16,782	17,158	7,359	**41,299**
06-99	0	1,478	560	**2,038**	16,825	17,391	7,448	**41,664**
07-99	122	1,468	580	**2,170**	16,866	17,405	7,506	**41,777**
08-99	155	1,524	637	**2,316**	16,860	17,401	7,572	**41,833**
09-99	197	1,605	687	**2,489**	17,036	17,647	7,699	**42,382**

American Indian Enrollment

Many American Indian children have been enrolled in Medicaid and M-SCHIP since the inception of the program in July of 1998. Many of the American Indian enrollees live in reservation areas of South Dakota where poverty is extreme. As a result a disproportionate number of American Indian children are eligible for benefits when compared to the rest of the South Dakota population.

The enrollment data shows 501 American Indian children were enrolled into M-SCHIP and 1,881 American Indian children have been added to Medicaid for this reporting period. The American Indian children represent 20 % of the total M-SCHIP enrollment. We feel the outreach to this targeted population has been successful in enrolling children into both programs.

The following table illustrates the growth in monthly enrollment for American Indian children from July 1998 to September 1999. The June 1998 data does not reflect M-SCHIP data, as M-SCHIP began on July 1, 1998. However under the column 'ALL Medicaid American Indian Children Monthly Enrollment by Age Categories, June 1998 data is included as a starting point. The data for the following table was obtained from MMIS.

M-SCHIP American Indian Children Monthly Enrollment by Age Categories					**All Medicaid American Indian Children (Including M-SCHIP except for 6-98) Monthly Enrollment by Age Categories**			
Month	**0 - 5**	**6 - 12**	**13 - 18**	**Total**	**0 - 5**	**6 - 12**	**13 - 18**	**Total**
06-98	NA	NA	NA	**NA**	6,230	7,171	2,464	**15,865**
07-98	NA	51	16	**67**	6,303	7,323	2,888	**16,514**
08-98	NA	98	37	**135**	6,342	7,441	2,960	**16,743**

09-98	NA	138	51	**189**	6,358	7,488	3,000	**16,846**
10-98	NA	176	64	**240**	6,372	7,587	3,006	**16,965**
11-98	NA	194	72	**266**	6,416	7,616	3,041	**17,073**
12-98	NA	207	88	**295**	6,461	7,653	3,131	**17,245**
01-99	NA	223	108	**331**	6,438	7,656	3,183	**17,277**
02-99	NA	233	103	**336**	6,438	7,806	3,224	**17,468**
03-99	NA	230	98	**328**	6,497	7,835	3,309	**17,641**
04-99	0	223	104	**327**	6,506	7,808	3,333	**17,647**
05-99	0	234	109	**343**	6,460	7,811	3,359	**17,630**
06-99	0	269	116	**385**	6,488	7,958	3,395	**17,841**
07-99	16	263	127	**406**	6,549	7,959	3,455	**17,963**
08-99	21	289	153	**463**	6,567	7,936	3,469	**17,972**
09-99	32	309	160	**501**	6,638	8,063	3,546	**18,247**

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

By far American Indian persons are the largest minority in South Dakota. South Dakota's total population is approximately 7% American Indian. The majority of this population resides on the nine reservations in the state, and for this reason there has been significant consideration in targeting outreach to this population as follows.

A Tribal Consultation meeting was held April 1999 with officials from each Tribal government, and representatives from IHS invited. The Department of Social Services has also invited representatives from IHS and Tribal governments to be on the Medicaid Advisory Committee that meets quarterly. We feel this has been a successful method to include American Indian representation for M-SCHIP and plan to continue this effort.

The Rosebud Indian Reservation requested training specifically for the Community Health Representatives (CHR's) regarding M-SCHIP. This was done by a Department of Social Services supervisor in addition to the training that was conducted for local outreach in the community. The M-SCHIP radio ad that aired statewide was provided to the Rosebud radio station, KINI, and was tailored to the American Indian population in that area.

A radio announcement to promote M-SCHIP to all children that might be eligible was aired in November 1998 on networks that reached communities throughout the state. There were two hundred twenty five purchased advertising times as well as free public service announcement spots.
Attachment # 18: Radio ads and coverage areas.

The M-SCHIP poster and brochure were designed with a culturally sensitive logo to represent children of

varying ethnic backgrounds in an effort to convey that all children can apply for the program. Attachment # 19: Brochure.

All DSS offices have policies and procedures in place that they can rely on to communicate with limited English proficient (LEP) persons. One geographical area (Minnehaha County) contains the vast majority of limited English proficient persons residing in South Dakota and therefore has taken the most active approach in providing interpreter services. The LEP policies and procedures were reviewed and accepted by the Department of Health and Human Services /Office Inspector General/Office for Civil Rights. Attachment # 20: DSS Effective Communication Policy and Procedures.

We feel that we are reaching the various geographic and minority populations of South Dakota and that Community based outreach methods have been successful.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

The following Department of Social Services surveys shed some light on the outreach efforts that have been used in the community based outreach approach. It has been beneficial to look at the movement of outreach effectiveness from the first survey period to the survey conducted one year later, where we see local outreach and alternative locations replacing the DSS as sources of M-SCHIP information.

The Department of Social Services developed and administered a random survey that was sent out December 1998 to 167 households that had an eligible M-SCHIP recipient. This figure represented a 15% random sample. The purpose of the project was to obtain data to use as a baseline and to aid in the evaluation of the program. In November 1999 another random survey was sent out to 544 households that had an eligible M-SCHIP recipient. This figure represented a 20% random sample. Specific questions were developed to gather data on outreach effectiveness.

The following results are from the 1998 Department survey questions relating to the effectiveness of outreach:

76.1% of the respondents heard about M-SCHIP from the Department of Social Services, 4.3% from Community Health Nurse, 2.2% from the Brochure, 2.2% from the radio, 2.2% from Tribal Health, and 13% from various other methods such as: physician, phone call, newspaper, Mental Health, school, hospital, Caring Program, and word of mouth.

93% obtained the application from the Department of Social Services, 1.2% from the Community Health Nurse, 1.2% from physician office, 2.3% from Tribal Health, 2.3% Other that included Mental Health and mailed to them.

95.4% said the application was easy to complete, 2.3% said slightly difficult, 0% said difficult, and 2.3% did not answer.

The survey shows that the Department of Social Services was very effective in reaching the communities with outreach on M-SCHIP. Along with effectively reaching the people about the new program they were the key source for providing applications. The improvements in the application by making it simplified and shorter also netted high positive feedback from the applicants.
Attachment # 11: Department survey 1998.

When comparing the 1999 Department survey to the 1998 survey the following results show that the community based outreach efforts are bearing fruit. The respondents are hearing about the program from a variety of community sources. Applications are also being obtained from various community locations in comparison to the 1998 survey results. The following are survey results that relate to outreach efforts.

55% of the respondents heard about M-SCHIP from the Department of Social Services, 10% from Community Health Nurse, 4% from the Brochure, 4% from the Poster, 4% from Primary Care Provider, 4% from Hospital, 4% from School, 3% from Newspaper article, 1% from Tribal Health/IHS, 1% from Radio, 10% from Other methods such as: Headstart, Salvation Army, friend, relative, Daycare, work, letter, newsletter from physician, WIC, mail, physicians office.

86 % obtained the application from the Department of Social Services, 3.3% from Community Health Nurse, 3.3% from Doctor's office/clinic, 1% from Hospital, 1% from School, 0.3% from Tribal Health, 5.1% from Other methods such as: Counselors office, Headstart, mail, Salvation Army, Day care, School, WIC.

96% said they did not have any difficulty filling out the application, and 4% indicated they had some trouble but noted that the caseworker helped them complete it.

98% responded that they did not have any difficulty with the enrollment process, such as obtaining a form, knowing where to send it after completing it. Of the 2% that said they had trouble with it they commented that a caseworker or relative had helped them.
Attachment # 12: Department 1999 survey.

No entity in South Dakota has successfully obtained grant funding for outreach programs. However, we eagerly anticipate a successful applicant for a grant from the Robert Wood Johnson foundation for "The South Dakota Covering Kids Initiative" for this year.

3.5 What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 2108(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

Table 3.5**

Type of coordination	Medicaid*	Maternal and child health	Other (specify) ____WIC_____	Other (specify) _State Child Care Office____
Administration				
Outreach		Yes-in conjunction with the Department of Health	Yes-in conjunction with the local WIC offices	Information sent from the state office to newly licensed child care places in the state.
Eligibility determination				
Service delivery				
Procurement				
Contracting				
Data collection		Yes- in conjunction with the Department of Health through the BFRSS survey; Immunization initiative with the Department of Health		
Quality assurance		Department of Health studies that coincide with our performance measures will be reviewed.		
Other (specify)				
Other (specify)				

** South Dakota has a Medicaid SCHIP expansion program.

*Note: This column is not applicable for States with a Medicaid CHIP expansion program only.

Table 3.5				
Type of coordination	Other (specify) _Department of Education____	Other (specify) _Low Income Energy Assistance Programs_____	Other (specify) __State Child Support Enforcement	Other (specify) _Child Protection Office
Administration				
Outreach	Yes-coordinate with state office to disseminate M-SCHIP information	Yes-coordinate with state office to disseminate M-SCHIP information	Yes-planning stages with state office to disseminate M-SCHIP information	Yes-planning stages with the state office to disseminate M-SCHIP information
Eligibility determination				
Service delivery				
Procurement				
Contracting				
Data collection				
Quality assurance				
Other (specify)				
Other (specify)				

** South Dakota has a Medicaid SCHIP expansion program

Table 3.5				
Type of coordination	Other (specify) _ Headstart	Other (specify) Disproportionate Share Hospitals___	Other (specify) __ Indian Health Services	Other (specify) _____
Administration			Yes	
Outreach	Yes-coordinate with the state office to disseminate M-SCHIP material to all state Headstart programs.	Yes	Yes	
Eligibility determination				
Service delivery			Yes	
Procurement			Yes	
Contracting				
Data collection			Yes-immunization data	
Quality assurance				
Other (specify) ___ Agreement		Agreement that they will provide an application and assist in the completion of application of potentially eligible children. They can bill for these completed applications.		
Other (specify)				

** South Dakota has a Medicaid SCHIP expansion program

3.6 How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

__X__ Eligibility determination process:

___ Waiting period without health insurance (specify)
_X_ Information on current or previous health insurance gathered on application (specify)
___ Information verified with employer (specify)
___ Records match (specify)
___ Other (specify)
___ Other (specify)

___ Benefit package design:

___ Benefit limits (specify)
___ Cost-sharing (specify)
___ Other (specify)
___ Other (specify)

___ Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify)
___ Other (specify) _____

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

In the Medicaid expansion model and the income categories targeted so far, crowd out has not been viewed as a significant issue, however monitoring has occurred. Our program design provides no incentive for a family to drop insurance coverage because the children who are insured qualify for benefits under Medicaid and only the children who are uninsured are enrolled in M-SCHIP. In as much as families already made their decision to have insurance, additional benefits of having Medicaid insurance are still available to them.

The Department of Social Services developed and administered a random survey containing questions relating to insurance coverage to address crowd out. The survey was sent out in December 1998 to 167 households representing a 15% random sampling of M-SCHIP recipients. The purpose of the project was to assist in obtaining data to aid in the evaluation of the program. The return rates on the survey were comparable for white and American Indian survey participants. A return rate of 51.5% or 86 returned surveys was obtained from the survey.

For FY 1998 from the M-SCHIP Department Survey we have the following results from questions relating to health insurance coverage:

- 45.3% of the households said their employer does not offer health insurance coverage for dependent children; 36.1% said their employer does offer health insurance coverage for dependent children; 18.6% said it was not applicable to them.

- 64.6% of the households responded they did not have coverage through their employee health plan due to cost of premiums; 13.4% said they had no coverage due to high deductibles; 14.6% listed other reasons; 3.7% did not think it was necessary or personal choice to not have insurance; 3.7% dropped insurance because this program was available. The 3.7% is 3 respondents out of the 82 that gave reasons for not having health insurance through an employer.
  Attachment # 11: 1998 Department Survey

The results of the 1998 survey show that only a small number, 3 out of 82, dropped their private health insurance because M-SCHIP was available. From this preliminary data it appears that crowd out is not an issue.

The December 1999 Department M-SCHIP survey was sent out to 544 households with an M-SCHIP recipient. This survey represented a 20% random sampling of M-SCHIP households and netted a 56.8% return rate or 309 returned surveys. The questions relating to health insurance show the following results.

- 39.2% of the households said their employer does offer health insurance coverage for dependent children; 38.5% said their employer does not offer health insurance coverage for dependent children; and 22.3% said this was not applicable to them listing reasons such as self employed, unemployed, part time employment, student status, will have insurance once waiting period is over.

- 54.1% of the households said they did not have coverage through their employee health plan due to cost of premiums; 9% said it was due to high deductibles; 19.3% stated it was not available; 13.3% listed other reasons that included unemployed, self employed, waiting period, preexisting condition, part time work, spouse to carry insurance; 3.3% did not think it necessary until needed or personal choice; 1 % dropped insurance because M-SCHIP available. Out of 305 responses, 3 indicated they had dropped insurance because of the availability of M-SCHIP for a rate of 1%.
  Attachment # 12: 1999 Department Survey

  Comparing the two years of survey information we see that 78% in 1998 and 63.1% in 1999 continue to report that they do not have insurance coverage for dependent children either due to cost of premiums or high deductibles. Responses show that employers' not offering health insurance coverage to dependent children continues to be high with 45.3% in 1998 and 38.5% in 1999. These high percentages for both not offering insurance and the cost of insurance continue to point out the need for M-SCHIP to provide insurance coverage for children in our state.

  When we compare the results from the 1998 and the 1999 survey, we find that the number of

respondents that have dropped their insurance coverage due to the M-SCHIP program is low and actually decreased in the second year. While we are aware of this as an important issue and plan to continue monitoring this, it does not appear to adversely effect our program design at this time.

SECTION 4. PROGRAM ASSESSMENT

This section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Table B: provided by Mathematica Policy Research for the Title XXI evaluation Report for March 2000.

South Dakota
(Table B)

M-SCHIP Enrollment Statistics FFY 1998[a] and FFY 1999

Table 4.1.1 in NASHP Framework for State Evaluations

Characteristics	Number of children ever enrolled		Average number of months of enrollment		Year end enrollees as percentage of unduplicated enrollees per year	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	1,047	3,191	2.1	6.6	89.9%	72.5%
Age						
Under 1	0	11	-	3.2	-	100.0%
1-5	0	201	-	2.6	-	85.1%
6-12	671	1,821	2.1	7.0	89.6%	73.3%
13-18	376	1,158	2.1	6.7	90.4%	68.9%
Countable Income Level						
<=150% FPL	1,047	3,191	2.1	6.6	90.4%	72.5%
Age and Income						
Under 1						

Developed by the National Academy for State Health Policy

<=150% FPL	0	11	-	3.2	-	100.0%
1-5						
<=150% FPL	0	201	-	2.6	-	85.1%
6-12						
<=150% FPL	671	1,821	2.1	7.0	89.6%	73.3%
13-18						
<=150% FPL	376	1,158	2.1	6.7	90.4%	68.9%
Type of plan						
Fee-for-service	131	701	2.0	1.8	57.3%	2.9%
Managed care	0	0	-	-	-	-
PCCM	916	2,490	2.1	8.0	94.5%	92.1%

a. South Dakota began reporting enrollment data for its M-SCHIP program in Quarter four, FFY 1998; therefore, data for FFY 1998 are only partial year.

*Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150% FPL. See the HCFA Quarterly Report instructions for further details.

SOURCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

Attachment # 21: HCFA-21.E and HCFA-64EC for FFY 1998

Attachment # 22: HCFA-21.E and HCFA-64EC for FFY 1999

M-SCHIP Enrollment by Age and Race

The following table illustrates M-SCHIP enrollment by Age and Race for the reporting quarters for FFY 1998 and FFY 1999. Data obtained from MMIS.

Attachment #24: County M-SCHIP Enrollment Map by Race for FFY 1998 and FFY 1999.

M-SCHIP Enrollment by Age and Race for FFY 1998 and FFY 1999												
FFY Quarter	**White**				**American Indian**				**Other**			
	0-5 yrs	**6-12 yrs**	**13-18 yrs**	**Total**	**0-5 yrs**	**6-12 yrs**	**13-18 yrs**	**Total**	**0-5 yrs**	**6-12 yrs**	**13-18 yrs**	**Total**
FFY 1998-4th Qtr (data from MMIS 9-98)	NA	476	196	672	NA	138	51	189	NA	34	08	42
FFY 1999 - 1st Qtr(data from MMIS 12-98)	NA	729	308	1,037	NA	207	88	295	NA	56	17	73
FFY 1999 - 2nd Qtr(data from MMIS 03-99)	NA	930	370	1,300	NA	230	98	328	NA	63	19	82
FFY 1999 - 3rd Qtr(data from MMIS 06-99)	0	1124	422	1,546	0	269	116	385	0	85	22	107
FFY 1999 - 4th												

Qtr(data from MMIS 09-99)	144	1216	502	1,862	32	309	160	501	21	79	25	125

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

The application form asks if the child currently has health insurance, but does not ask if the child has previously been enrolled in a health insurance plan. Because of our program design with access to Medicaid or M-SCHIP it has not been important to know about previous status only the current status is important regarding health insurance.

M-SCHIP families needed help getting access to coverage for their children. This has been evident by the responses to both the 1998 and 1999 Department surveys that were sent to M-SCHIP recipient households. Specific questions were designed to ask about health insurance coverage prior to enrollment in M-SCHIP. The following responses were from the 1998 survey.

- 59.3% of the respondents said their child went with out medical care due to cost before being covered by M-SCHIP, 40.7% said they did not go with out medical care before being in the plan.

- 45.3% of the households said their employer does not offer health insurance coverage for dependent children, 36.1% said their employer does offer health insurance coverage for dependent children, 18.6% said not applicable to them.

- 64.6 % of the households said they did not have coverage through their employee health plan due to cost of premiums, 13.4% said it was due to high deductibles, 14.6% listed other reasons, 3.7% did not think it was necessary or personal choice, 3.7% dropped insurance because this program was available.

The results show that a large percentage of children were without health insurance coverage for two major reasons, cost of premiums and high deductibles along with employers not offering insurance for dependent children.

The Department FY 1999 M-SCHIP Survey questions showed similar findings when comparing them to the 1998 survey results.

- 60% of the respondents said their child went with out medical care due to cost before being covered by M-SCHIP, 40% said they did not go with out medical care before being in the plan.

- 39.2% of the households said their employer does offer health insurance coverage for dependent children, 38.5% said their employer does not offer health insurance for dependent children; 22.3% said it was not applicable to them for reasons that included unemployed, self employed, student

status, part time employment, would have after waiting period ended.

- 54.1% of the households said they did not have coverage through their employee health plan due to cost of premiums, 9% said it was due to high deductibles, 19.3% stated it was not available, 13.3% listed other reasons which included such things as unemployed, self employed, waiting period, pre-existing condition, part time work, spouse suppose to carry insurance, 3.3% did not think it necessary until needed or personal choice, 1% dropped insurance because M-SCHIP available, this 1% was 3 out of 301 responses.
  Attachment # 11: Department Survey 1998
  Attachment # 12: Department Survey 1999

The survey responses show that for both years approximately 60% of the children that are now enrolled in M-SCHIP went without health care prior to enrollment. The majority of the reasons for no health coverage were the cost of premiums and high deductibles in conjunction with employers not offering insurance for dependent children. We will continue to monitor the responses to coverage prior to enrollment in M-SCHIP.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

Medicaid and M-SCHIP are the only State programs actually providing coverage to children. Many other programs in the state provide services within the limited scope of their program. They all collaborate to refer children to M-SCHIP to get targeted children enrolled in the program.

4.2 Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

The M-SCHIP disenrollee number from Table 4.1.1 was 1178. This information is from the HCFA 64.21E data information supplied to Mathematica Policy Research, Table C.

A Department study done from eligibility data from 07-98 through 07-99 showed 1,329 disenrollees. Disenrollment rates for M-SCHIP have been comparable to other low-income Medicaid disenrollment rates. See Table 4.2.3 for reasons and rates of disenrollment from this study.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

We do not have a renewal process. The Title XIX, Medicaid, annual eligibility redetermination process is utilized. There is no data available if the child went to Private Health Insurance after leaving

M-SCHIP.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

Data Source: DSS Eligibility computer system. Methodology: Review of disenrollee files for closure codes. Reporting period: 07-1998 through 07-1999.

Table 4.2.3

Reason for discontinuation of coverage	Medicaid CHIP Expansion Program: Yes		State-designed CHIP Program: NA		Other CHIP Program*: _____NA_____	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total	1329	100%				
Access to commercial insurance						
Eligible for Medicaid	824	62%				
Income too high	159	12%				
Aged out of program						
Moved/died	48	4%				
Nonpayment of premium						
Incomplete documentation						
Did not reply/unable to contact	114	8%				
Other (specify) Other	141	11%				
Other (specify) Recipients request	43	3%				
Don't know						

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

Our program does not automatically disenroll children from M-SCHIP. Annual reviews are required. At the time when annual reviews are due attempts are made to contact the families and review forms are mailed to the recipient household. If there is no response from the family then the DSS eligibility workers are encouraged to attempt contact with the family before a case is closed, and this review process successfully re-enrolls over 90% of the children with M-SCHIP eligibility.

4.3 How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 __ $ 129,701.00_____

FFY 1999 ____$ 2,020,545.00 _____

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1 CHIP Program Type __Medicaid CHIP Expansion

Type of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Total expenditures	$60,479.00	$ 1,740,433.00	$46,829.00	$ 1,352,491.00
Premiums for private health insurance (net of cost-sharing offsets)*	NA	NA	NA	NA
Fee-for-service expenditures (subtotal)				
Inpatient hospital services	$ 3,053.00	$380,376.00	$2,364.00	$295,591.00
Inpatient mental health facility services	0	0	0	0
Nursing care services	0	0	0	0
Physician and surgical services	$11,526.00	$313,526.00	$8,925.00	$243,641.00
Outpatient hospital services	$ 7,627.00	$203,304.00	$5,906.00	$157,987.00
Outpatient mental health facility services	0	0	0	0
Prescribed drugs	$16,928.00	$221,765.00	$13,107.00	$172,334.00
Dental services (Premiums Delta Dental)	0	$135,976.00	0	$105,667.00

Vision services	$ 1,996.00	$ 18,820.00	$1,546.00	$ 14,626.00
Other practitioners' services	$12,010.00	$219,373.00	$9,299.00	$170,475.00
Clinic services	$ 1,912.00	$109,178.00	$1,480.00	$ 84,843.00
Therapy and rehabilitation services	0	0	0	0
Laboratory and radiological services	$ 601.00	$ 28,233.00	$ 465.00	$ 21,940.00
Durable and disposable medical equipment	0	$ 1,634.00	0	$ 1,269.00
Family planning	0	0	0	0
Abortions	0	0	0	0
Screening services	$ 463.00	$ 6,306.00	$ 359.00	$ 4,900.00
Home health	$ 9.00	$ 1,870.00	$ 7.00	$ 1,453.00
Home and community-based services	0	0	0	0
Hospice	0	0	0	0
Medical transportation	$ 211.00	$ 7,389.00	$ 163.00	$ 5,742.00
Case management	$ 2,274.00	$ 53,850.00	$1,761.00	$41,847.00
Other services	$ 1,869.00	$ 38,833.00	$1,447.00	$30,176.00

Attachment # 23 : HCFA-64.21U

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap?

Activities funded under the 10 per cent cap include CHIPS Indirect, District program Supervisor, Field Clerical Support, Eligibility Determination.

What role did the 10 percent cap have in program design?

There was no direct effect on the program design, however, because of the cap expenses for staff time, forms, etc that would have been charged to CHIP if there were no cap were covered by other funding sources.

Table 4.3.2

Type of expenditure	Medicaid Chip Expansion Program YES		State-designed CHIP Program NA		Other CHIP Program* NA	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share	$69,222.00	$280,112.00	NA	NA	NA	NA
Outreach	$13,114.00	$ 35,768.00	NA	NA	NA	NA
Administration	$56,108.00	$244,344.00	NA	NA	NA	NA
Other_____	NA	NA	NA	NA	NA	NA
Federal share	$53,598.00	$217,675.00	NA	NA	NA	NA
Outreach	$10,154.00	$27,796.00	NA	NA	NA	NA
Administration	$43,444.00	$189,879.00	NA	NA	NA	NA
Other ___	NA	NA	NA	NA	NA	NA

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

_X_ State appropriations
___ County/local funds
___ Employer contributions
___ Foundation grants
___ Private donations (such as United Way, sponsorship)
___ Other (specify) _____

4.4 How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

Table 4.4.1

Approaches to monitoring access	Medicaid CHIP Expansion Program Yes	State-designed CHIP Program NA	Other CHIP Program* NA
Appointment audits	No		
PCP/enrollee ratios	Yes		
Time/distance standards	Yes		
Urgent/routine care access standards	PCCM requirements assure 24 hour/7 days a week access to the individual's Primary Care Provider in some manner. Each PCP signs an addendum whereby they promise to be available to their Medicaid patients. Medical Services conducts phone surveys with providers to verify that around the clock access is being provided.		
Network capacity reviews (rural providers, safety net providers, specialty mix)	Yes - Periodic reviews are made of PCP/enrollee ratios		
Complaint/grievance/ disenrollment reviews	Complaint/grievance - Yes Disenrollment reviews - No		
Case file reviews	Yes		

Beneficiary surveys	Yes - Managed Care Recipient Satisfaction Survey; Department Survey to recipient households.		
Utilization analysis (emergency room use, preventive care use) State Plan Performance Measures See Table 1.3	Performance studies - performance measures stated in State plan, see Table 1.3.		
Other (specify) _____			
Other (specify) _____			
Other (specify) _____			

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3. NA

Table 4.4.2

Type of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Requiring submission of raw encounter data by health plans	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No
Other (specify)_____	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

M-SCHIP recipients are enrolled in the PCCM program and become part of the managed care population. Since they are a part of the managed care program they benefit from the PCCM standards for access to and quality of care services. Most of the specialized physicians participate, all hospitals in the state participate, all IHS participates, pharmacies almost have universal participation and dental participation is 78%. The current statewide PCP/enrollee ratio is one provider to every 85 managed care recipients. See table below for the number of providers by specialty that are currently serving our managed care population that also includes M-SCHIP enrollees.

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
1. Pediatricians	55	53 (8 are out-of-state providers)	53
2. Family Practitioners	331	312 (61 are out-of-state providers)	312
3. Internists	181	93 (4 are out-of-state providers)	93
4. General Practitioners	Included w/FP's	Included w/FP's	
5. OB/GYN, and GYN	43	55 (1 is an out-of-state provider)	55
6. FQHCs	13	20 (1 is an out-of-state provider)	20
7. RHCs	34	58 (7 are out-of-state providers)	58
8. Nurse Practitioners			
9. Nurse Midwives			
10. Indian Health Service Clinics	15	21 (1 is an out-of-state provider)	21

Providers	# Before the Waiver	# In Current Waiver	# Expected in Renewal
Clinics			
Additional Types of Provider to be PCCMs			
1.Air Force Base Clinics	0	1	1

Time and distance standards are that no recipient in the state has to travel more then 75 miles to their PCP. If they have to travel more then this distance, they may be exempt from managed care. Also, they are included in the managed care studies.

The Department of Social Services developed and administered a random survey that was sent out December 1998 to 167 households that had an eligible M-SCHIP recipient. This figure represented a 15% random sample that yielded a return rate of 51.5% or 86 responses. The return rates on the survey were comparable for white and Native American survey participants. The purpose of the project was to obtain data to aid in evaluation of the program.
The survey instrument consisted of several questions directed at obtaining information about access to care. The following summarizes the results of these questions.
Attachment: # 11: 1998 Department survey.

- 60.5% of the children have had at least one routine check up not related to illness or injury with their primary care provider since enrolled in the plan.
- 57% of the children have had a vision examination since being enrolled in the health care program.
- 71% reported that their child had a dental examination. The second part of the question showed that 52.3% of the children went with out dental care due to cost prior to being in M-SCHIP.
- 95.3% of the households said they chose their child's primary care provider.
- 94.2% said they were satisfied with the preventative care that they had been able to get since being on the program.
- 94.2% responded that they felt their PCP was providing quality care for their child.

The results show that a large percentage of respondents were satisfied with the care they received for their child. It is also significant to note that 60.5% of the children received at least one routine health care visit unrelated to injury or illness since on the program, showing that families are utilizing preventative services.

In November 1999 another Department of Social Service M-SCHIP random survey was sent out to 544 households that had an eligible M-SCHIP recipient. This figure represented a 20% random sample and netted a return rate of 56.8%. Specific questions were again targeted to access to care and

satisfaction. The following results were noted.
Attachment # 12: 1999 Department survey

- 57.1% responded that their child had at least one visit for a routine well child care check up with their primary care provider, not related to illness or injury since enrollment in M-SCHIP.

- 64.7% reported their child had a dental examination since enrolling in the M-SCHIP program. The second part of the question showed that 47.5% of the children needed dental care but did not receive it due to cost before being covered by M-SCHIP.

- 54.8% reported having a vision exam since being enrolled in M-CHIP. Part two of the question showed 37.1% needed vision care but did not receive it due to cost before being covered by M-SCHIP.

- 93.2% replied that they were able to get medical care for their child when it was needed.

- 98% responded they felt that the PCP was providing quality care for their child.

In comparing the two surveys the respondents consistently report that they are satisfied with the quality of care their child is receiving on the program. It should be noted that although children are receiving well childcare visits, this is one area where more information and education is needed to promote the preventative healthcare services that is available through this program. Plans to change the EPSDT notification letters to households are underway. The letter is being revised to make it easier to understand and to provide age specific information for preventative health care for the child.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

Since the M-SCHIP enrollees are included in the Medicaid waiver they will be included in the operation of the waiver.

Department surveys with questions relating to access of care will continue to be sent to households of M-SCHIP recipients. We will continue to survey on a periodic basis.

We will continue liaison with most provider groups through M-SCHIP outreach and the Medicaid provider group.

4.5 How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees,

particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

Table 4.5.1

Approaches to monitoring quality	Medicaid CHIP Expansion Program	State-designed CHIP Program NA	Other CHIP Program NA
Focused studies (specify)	PCCM		
Client satisfaction surveys	PCCM Department survey		
Complaint/grievance/ disenrollment reviews	PCCM		
Sentinel event reviews			
Plan site visits			
Case file reviews	Yes - upon complaints.		
Independent peer review			
HEDIS performance measurement			
Other performance measurement (specify)	Yes per State Plan		
Other (specify) SURS Unit in DSS	SURS unit conducts post reviews to detect fraud and abuse.		
Other (specify) PRO(Professional Review Organization)	PRO conducts random post care reviews.		
Other (specify) _Phone Surveys with Providers	PCCM department conducts phone surveys with providers to verify that around the clock access is being provided.		

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

Our office has put a renewed emphasis on measuring the quality of services provided to all Medicaid recipients. We rely on recipient surveys, individual contacts, and periodic analysis of the services provided to our recipients to identify possible quality of care issues.

According to our 1999 recipient survey results, 98% of those responding had a favorable opinion of the

quality of services provided to their children by the child's PCP. This is a 3.8% increase from the 1998 survey. The 1999 recipient survey also showed an increase of 2.4% in regards to the satisfaction of preventative care provided to the children eligible for M-SCHIP. Overall, our recipients report receiving good quality of care while eligible for M-SCHIP.
Attachment # 11 and # 12: Department surveys 1998 and 1999.

Our managed care area currently conducts quality assurance studies in a number of areas. Examples of the studies that have been completed include: Immunization, Well Child Visits, Optometric Services, Mental Health/Eating Disorders, Asthma, Substance Abuse, and Dental Services. Copies of the previously mentioned studies are attached.
Attachments # 4 through # 10: Performance Measure Studies

We will continue these Quality Assurance studies and pursue action to obtain measurable improvement. Since M-SCHIP has only been in operation for a short time, it is difficult to draw any significant conclusions about our M-SCHIP population at this time.

4.5.3. What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

The department periodically monitors access to care issues through recipient surveys and direct contact from our M-SCHIP enrollees. When an issue is identified our department promptly works one on one with the recipient and/or providers to address any access to care issues. Access to care results are included on the attached surveys. Future survey results will be included with the next reporting requirement.
Attachment # 11: Department survey 1998.
Attachment # 12: Department survey 1999.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

Attachment 1: Application Form
Attachment 2: Managed Care Enrollment Data
Attachment 3: Healthy Kids Klub Brochure and EPSDT Notification Letter
Attachment 4: Immunization Study
Attachment 5: Well Child Visit Study
Attachment 6: Optometric Study
Attachment 7: Mental Health Study/Eating Disorders Study
Attachment 8: Asthma Study
Attachment 9: Substance Abuse Study
Attachment 10: Dental Study
Attachment 11: Department Survey 1998
Attachment 12: Department Survey 1999
Attachment 13: Behavioral Risk Factors Surveillance System Survey 1998 and 1999
Attachment 14: Indian Health Service Primary Care (PCP) List

Attachment 15: Urban Institute Estimates/State-By-State Change in Enrollment
Attachment 16: South Dakota Managed Care Waiver
Attachment 17: Managed Care Referral Card and Information Sheet
Attachment 18: Radio Announcement and Coverage Area Map
Attachment 19: M-SCHIP Brochure
Attachment 20: Department of Social Services Effective Communication Policy
Attachment 21: FFY 1998 Forms HCFA-64EC and HCFA-64.21E
Attachment 22: FFY 1999 Forms HCFA-64EC and HCFA-64.21E
Attachment 23: FFY 1998 and FFY 1999 Forms HCFA-64.21U
Attachment 24: County M-SCHIP Enrollment Map by Race FFY 1998 and FFY 1999

SECTION 5. REFLECTIONS

This section is designed to identify lessons learned by the State during the early implementation of its CHIP program as well as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation should conclude with recommendations of how the Title XXI program could be improved.

5.1 What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

The eligibility and application process has been simplified. Changes that have been made to the application form include being shortened from a lengthy 9-page application down to 3 pages that may be mailed into the local offices. A face to face interview is no longer required, and there are no assets tests. To facilitate the ease in obtaining applications, they have been made available at many community providers and locations, and may even be mailed to the applicant. It is felt that these changes have significantly benefited the applicants by making the enrollment process easier.

The above changes have allowed us to be very flexible in opportunities that are available for outreach. In many cases the eligibility caseworkers outreach with caregivers, and staff might actually be establishing rapport in these instances. It has provided us the opportunity to be central to geographical areas and culturally sensitive to the populations specific to these areas.

Statewide coordination of outreach from the office of Medicaid Eligibility and the Office of Medical Services provides valuable direction to local workers. This facilitates sharing of information between the Field Program Specialists and the local offices, which in turn provides a method for uniform guidance for outreach efforts. It also provides linkages for other programs including the Department of Health, Department of Education, and IHS thereby creating other outreach opportunities.

5.1.2 Outreach

Outreach is an ongoing process. The local eligibility caseworkers are required to make periodic contact with community providers, agencies, and interested parties who could be a source of information and referral for M-SCHIP. Outreach is continually expanding and improving as community members' change and new ideas for outreach are pursued Cooperation and coordination with other state programs and interested parties is of the utmost importance to the continuation of M-SCHIP in South Dakota.

Outreach is a vital component to reaching the uninsured children in the state, thus it continues to be an area that will be reviewed for new ideas and improvements on existing methods. As part of the outreach another radio ad campaign will be implemented prior to the start of the new school year in August 2000.

We continue to believe that locally directed outreach is most effective for strong community collaborations. Statewide coordination from Offices of Program Management, Office of Medical Services and Medical eligibility strengthens local efforts by involving multiple programs.

We recognize that statewide coordination could be enhanced. We are very supportive of the outreach efforts of the Covering Kids Coalition that are in development in our state.

5.1.3 Benefit Structure

Children enrolled in M-SCHIP are eligible for the full benefits of the Medicaid program. We think this is the broadest and most appropriate benefit package for children. It includes covered services ranging from preventative health care to comprehensive treatment of health conditions. The absence of copayments along with wide provider participation facilitates the enrollees to utilize the benefits package.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

NA

5.1.5 Delivery System

The Medicaid program was an established program with excellent participation from providers throughout the state. By piggybacking on the Medicaid provider network the M-SCHIP recipients could receive immediate services. This was a definite advantage to the implementation of M-SCHIP.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

M-SCHIP in South Dakota is a Medicaid expansion. There is no penalty for a child with insurance that is eligible to not be enrolled in the Medicaid program. This allows us to market the program to all children and target enrollment within the established income levels. This provides wrap around coverage for the family that has other

children enrolled in Medicaid, and most importantly gets the children into Medicaid's comprehensive coverage. Medicaid benefits include access to many services not ordinarily covered by private insurance.

5.1.7 Evaluation and Monitoring (including data reporting)

Data reporting will continue as directed by HCFA.

Evaluation of utilization of services will continue to be an area that is looked at for the M-SCHIP recipients.

5.1.8 Other (specify) NA

5.2 What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

The 2000 Legislative session with the Governor's approval passed a bill that would raise M-SCHIP up to 200% of the FPL. This is in the planning and development phases and scheduled for implementation July 1, 2000.

5.3 What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

South Dakota is in agreement with the position advanced by the American Public Human Services Association in responding to the proposed SCHIP regulations.

Addendum

Addendum to Table 3.1. Provided by Evaluation Framework Workgroup.

The following questions and tables are designed to assist states in reporting countable income levels for their Medicaid and SCHIP programs and included in the NASHP SCHIP Evaluation Framework (Table 3.1.1). This technical assistance document is intended to help states present this extremely complex information in a structured format.

The questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and State-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your eligibility criteria as of **September 30, 1999.** Also, if the rules are the same for each program, we ask that you enter duplicate information in each column to facilitate analysis across states and across programs.

If you have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to Medicaid, please check here **9** and indicate who you passed it along to. Name_____, phone/email_____

3.1.1.1 For each program, do you use a gross income test or a net income test or both?

Title XIX Child Poverty-related Groups ____Gross _X__Net ____Both

Title XXI Medicaid SCHIP Expansion ____Gross _X__Net ____Both

Title XXI State-Designed SCHIP Program ____Gross ____Net ____Both

Other SCHIP program_____ ____Gross ____Net ____Both

3.1.1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups _140_% of FPL for children under __age 19
_____% of FPL for children aged _____
_____% of FPL for children aged _____

Title XXI Medicaid SCHIP Expansion _140_% of FPL for children aged _under 19
_____% of FPL for children aged _____
____% of FPL for children aged _____

Title XXI State-Designed SCHIP Program ____% of FPL for children aged _____
____% of FPL for children aged _____
____% of FPL for children aged _____

Other SCHIP program_____ ____% of FPL for children aged _____
____% of FPL for children aged _____
____% of FPL for children aged _____

3.1.1.3 Complete Table 3.1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)

Enter "Y" for yes, "N" for no, or "D" if it depends on the individual circumstances of the case.

Table 3.1.1.3

Family Composition	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program * _____

				___
Child, siblings, and legally responsible adults living in the household	D	D		
All relatives living in the household	D	D		
All individuals living in the household *	N	N		
Other (specify)				

* Assuming this section means some individuals are not relatives.

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded.

Enter "C" for counted, "NC" for not counted and "NR" for not recorded.

Table 3.1.1.4

Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Progra* _____
Earnings Earnings of dependent children	NC	NC		
Earnings of students (assuming is a parent)	C	C		
Earnings from job placement programs	C	C		
Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	NC	NC		
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	NC	NC		
Education Related Income Income from college work-study programs	NC	NC		
Assistance from programs administered by the Department of Education	NC	NC		
Education loans and awards	NC	NC		
Other Income Earned income tax credit (EITC)	NC	NC		
Alimony payments received	C	C		
Child support payments received	C	C		
Roomer/boarder income	C	C		
Income from individual development accounts	C	C		
Gifts	C	C		
In-kind income	C - if earned NC - if unearned	C - if earned NC - if unearned		

Program Benefits Welfare cash benefits (TANF)	NC	NC		
Supplemental Security Income (SSI) cash benefits	NC	NC		
Social Security cash benefits	C	C		
Housing subsidies	NC	NC		
Foster care cash benefits	NC	NC		
Adoption assistance cash benefits	NC	NC		
Veterans benefits	C	C		
Emergency or disaster relief benefits	NC	NC		
Low income energy assistance payments	NC	NC		
Native American tribal benefits	C	C		
Other Types of Income (specify)				

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.5 What types and *amounts* of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____
Yes __X__ No

If yes, please report rules for applicants (initial enrollment).

Table 3.1.1.5

Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings	$ 90.00	$ 90.00	$	$
Self-employment expenses	$ Actual *	$ Actual *	$	$
Alimony payments Received	$ 0	$ 0	$	$
Paid	$ Actual	$ Actual	$	$
Child support payments Received	$ 50.00	$ 50.00	$	$
Paid	$ Actual	$ Actual	$	$
Child care expenses (employment related)	$ Actual	$ Actual	$	$
Medical care expenses	$ NA	$ NA	$	$
Gifts	$ 30.00 per quarter	$ 30.00 per quarter	$	$
Other types of disregards/deductions (specify)	$	$	$	$

* Depreciation, cost of buildings, etc. - Not allowed as a deduction.

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups	_X_No	____Yes (complete column A in 3.1.1.7)
Title XXI SCHIP Expansion program	_X_No	____Yes (complete column B in 3.1.1.7)
Title XXI State-Designed SCHIP program	____No	____Yes (complete column C in 3.1.1.7)
Other SCHIP program_____	____No	____Yes (complete column D in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

Please indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for vehicles. If not applicable, enter "NA."

Table 3.1.1.7 Treatment of Assets/Resources	Title XIX Child Poverty-related Groups (A)	Title XXI Medicaid SCHIP Expansion (B)	Title XXI State-designed SCHIP Program (C)	Other SCHIP Program* (D)
Countable or allowable level of asset/resource test	$ NA	$ NA	$	$
Treatment of vehicles: Are one or more vehicles disregarded? *Yes or No*	NA	NA		
What is the value of the disregard for vehicles?	$ NA	$ NA	$	$
When the value exceeds the limit, is the child ineligible("I") or is the excess applied ("A") to the threshold allowable amount for other assets? *(Enter I or A)*	NA	NA		

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? _X_ Yes ___ No